DATE RECEIVED: _____ COMPLAINT NUMBER: _____

KENTUCKY STATE BOARD OF LICENSED DIABETES EDUCATORS
Complaint Form

Person Filing Complaint

Name:_____

Address: _____ City: _____ State: _____ Zip Code

Day Telephone: (___)_____ Evening Telephone: (__)_____

Name of Licensed Diabetes Educator

Name:_____

Address:_____ City: _____ State: _____ Zip Code:_____

Day Telephone: (___)_____

Name and phone number of persons who may provide additional information

1. Name _____ Telephone: ( )_____ Type of Information _____
2. Name _____ Telephone: ( )_____ Type of Information _____
3. Name _____ Telephone: ( )_____ Type of Information _____
4. Name _____ Telephone: ( )_____ Type of Information _____

Brief Summary of Complaint

(Please be as specific as possible regarding names, dates locations, and actions which you believe to be improper, unethical or unprofessional.)

By signing this complaint form, I hereby certify that the information is complete and true to the best of my knowledge.

Signature: _____ Date: _____

If your complaint concerns your treatment by this diabetes educator, please sign and enclose the “Client Agreement to Release Information” form.

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Send to: **STATE BOARD OF LICENSED DIABETES EDUCATORS**
PO BOX 1360
FRANKFORT KY 40602-1360
Phone: (502) 564-3296
Fax: (502) 564-4818

Authorization for Release of Medical Records to the Kentucky Board of Licensed Diabetes Educators

I,_____, the undersigned, do hereby authorize the full
print name here

release of any and all medical records, correspondence, billing information, from _____, Licensed Diabetes Educator, regarding the medical, diagnosis, assessment, evaluation, and/or treatment of me to the Kentucky Board of Licensed Diabetes Educator or any authorized agent or investigator of the Board.

I understand that the above records may be used by the Board in the investigation and possible disciplinary prosecution under KRS Chapter 309 against the diabetes educator. I further understand that the Board will make reasonable efforts to protect the confidentiality of my records under KRS Chapter 61 and Chapter KRS 13B, or other applicable law. This involves health oversight activities and administrative proceedings of the Board. As such, this disclosure is permitted under 45 C.F.R. Section 164.512(a), (d), and (e), the regulations implementing the Health Insurance Portability Accountability Act (HIPAA).

A photocopy of this authorization shall be deemed effective as an original.

This authorization shall be effective for one year from the date of signing.

_____ _____

Date

Signature of person, or parent/legal guardian if person is under 18 years of age

Kentucky Board of Licensed Diabetes Educators
PO Box 1360
Frankfort KY 40602
Telephone: (502) 564-3296
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